

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04379

04375

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 54 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road				d. STREET ADDRESS River Road			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Mae Last Cannon				4. DATE OF DEATH Month April Day 13 Year 19 62			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1894		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-2819		17. INFORMANT Address Annie Spry, Hurlock, Maryland, RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Diabetic Mellitus.						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-14 1944 to 4-13 1962 , that (I) (we) last saw the deceased alive on 4-13 1962 and that death occurred at 4:30 PM from the causes and on the date stated above.							
22a. SIGNATURE W. E. Lennon M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 16, 1962	
22c. PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.				22d. ADDRESS Federalsburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1937

CERTIFICATE OF DEATH

1937

(M)



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04376

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) or STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR HILLSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL HILLSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>NORMAN CARROLL FAULKNER</u>		4. DATE OF DEATH <u>APRIL 30 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NELSON FAULKNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY CARROLL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Melvin PEPPER, HILLSBORO</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO <u>6 months</u> (c) <u>Atherosclerotic & Hypertensive heart disease</u> DUE TO <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 Oct.</u> , 19 <u>61</u> , to <u>30 April</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>21 April</u> , 19 <u>62</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dale R. Kollman</u> M.D.		ADDRESS (Street, city or town, state) <u>16 N 2nd St.</u> DATE SIGNED <u>2-May-1962</u>	
PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>		<u>Denton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 3, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH VIRGIL MOORE & SON</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>MAY 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1917	
NAME OF DECEASED KIMMEL, MARY		SEX F	
AGE 77		COLOR W	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		CAUSE OF DEATH OLD AGE	
DATE OF DEATH 1917		PLACE OF DEATH BALTIMORE, MARYLAND	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	



TO ATTENTION OF
 THE CLERK OF THE
 BALTIMORE CITY CLERK'S OFFICE
 FOR RECORDING AND INDEXING

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04381

04377

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u>		c. LENGTH OF STAY IN 1b <u>65 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Friendship</u>				d. STREET ADDRESS <u>1 Near Friendship</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilhelm</u> Middle <u>Frederick</u> Last <u>Gadow</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ferdinand Gadow</u>				14. MOTHER'S MAIDEN NAME <u>Anna R. Beitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-6416</u>		17. INFORMANT <u>Frederick Gadow, Preston, Maryland, R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Cerebrovascular</u> DUE TO (b) <u>Recurrent Cerebrovascular Stroke</u> DUE TO (c) <u>Redundant Cerebrovascular Stroke caused Surgically 1/22/60</u> 151X Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> to <u>4/17</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>62</u> , and that death occurred at <u>4:35 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold B. Plummer, M.D.</u>				22b. ADDRESS <u>Preston, Maryland</u>		22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 19, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

64381

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/18/2011 BY 60322
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15M 9/60

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04382
CERTIFICATE OF DEATH
04378

1. PLACE OF DEATH a. COUNTY Caroline b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greensboro c. LENGTH OF STAY in 1b 5 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) None				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greensboro d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elsie S. Grimes		4. DATE OF DEATH Month April Day 7 Year 19 62					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30- 1909	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Crothers		14. MOTHER'S MAIDEN NAME ? Lynch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Walter Grimes Greensboro, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Lungs DUE TO Conditions, if any, which gave rise to immediate cause (b) Inoperable Carcinoma of the breast (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 1 1961 to Apr. 7 1962 , that (I) (we) last saw the deceased alive on Apr. 7 1962 , and that death occurred at 1:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Stonesifer 22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22b. DATE SIGNED Apr. 10 '62		22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62		23c. NAME OF CEMETERY OR CREMATORY Greensboro			
23d. LOCATION (City, town or county) Greensboro, Maryland		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Arthur S. House			
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie		24b. ADDRESS Greensboro, Md.		24c. DATE APR 13 '62			

1937

1937

Caroline

Caroline

Greenboro

Yrs.

Greenboro

None

None

Calnes

Calnes

1937-1938

White

W. A.

W. A.

None

Housewife

1 - 1938

William Grohner

None

10

Walter Grohner, Greenboro, N.C.

1937-1938

1937-1938

Greenboro, N.C.

1937-1938

1937-1938

1937-1938

Greenboro, N.C.

Greenboro, N.C.

Greenboro, N.C.

1937-1938

Greenboro, N.C.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04379**

04383

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X DENTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First GORMAN Middle HENRY Last				4. DATE OF DEATH APR 8 Month 8 Day 1962 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 18, 1912	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLEVELAND HENRY				14. MOTHER'S MAIDEN NAME MAUDE TOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. GORMAN HENRY Address DENTON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 581.1 IMMEDIATE CAUSE (a) Laennec's Biliary Cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes 2 yr						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 , 19 38 to APR 8 , 19 62 , that I last saw the deceased alive on April 8 , 19 62 , and that death occurred on 6:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 406 Market St DATE SIGNED ACTUAL SIGNATURE E. Paul Knotts M.D. PHYSICIAN'S NAME (Type) E. Paul Knotts M.D. Denton, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF APR 11, 1962		22c. NAME OF CEMETERY OR CREMATORY DENTON		22d. LOCATION (City, town, or county) (State) DENTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE De Virge Hoover ADDRESS Denton, Md				24a. REC'D BY REGISTRAR DATE APR 16 '62		24b. REGISTRAR'S SIGNATURE Clifford E. Thomas	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES W. BARRY		M		45		1900		BALTIMORE, MD		LABORER		MARRIED		WHITE		METHODIST		HIGH SCHOOL		MIDDLE CLASS		BALTIMORE, MD		JAN 15 1950		10:30 AM		HEART DISEASE		NATURAL		J. W. BARRY		J. W. BARRY		J. W. BARRY			
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF REGISTRAR		25. SIGNATURE OF WITNESSES		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF WITNESSES		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR		31. SIGNATURE OF WITNESSES		32. SIGNATURE OF PHYSICIAN		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF WITNESSES		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF REGISTRAR		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF WITNESSES	

Reg. Dist. No. 04380

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				1 d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROSA</u> First <u>JANET</u> Middle <u>PIPPIN</u> Last				4. DATE OF DEATH <u>APR.</u> Month <u>16</u> Day Year <u>1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 25, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>AMER</u>	
13. FATHER'S NAME <u>BRYAN COLEMAN</u>				14. MOTHER'S MAIDEN NAME <u>EMMA SKINNER</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>LUTHER PIPPIN, DENTON, MD</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>4 Oct.</u> 19 <u>61</u> , to <u>18 Apr.</u> 19 <u>62</u> that I last saw the deceased alive on <u>14 April</u> 19 <u>62</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dale R Kollman</u> M.D. <u>16 N. 2nd St.</u> PHYSICIAN'S NAME (Type) <u>Dale R. Kollman</u> <u>Denton, Maryland</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
<u>GREENS</u>		<u>APR. 18, 1962</u>		<u>GREENS BORO</u>				<u>GREENS BORO, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. ...</u> ADDRESS <u>Denton Md.</u>						24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04385

CERTIFICATE OF DEATH

Reg. Dist. No. 04381

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURKSVILLE</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURKSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>HENRY</u> Last <u>PUSEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 10, 1882</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>GEORGE PUSEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA OUELLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address <u>MRS MARTIN PUSEY DENTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>medullary Paralysis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular failure</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 31</u> , 19 <u>62</u> , to <u>April 17</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>62</u> , and that death occurred at <u>11:54</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Wearn MD.</u>		ADDRESS (Street, city or town, state) <u>214 W. Main Ave., Hagerstown, Md.</u>	
DATE SIGNED <u>APR 25 '62</u>		DATE SIGNED <u>APR 25 '62</u>	
PHYSICIAN'S NAME (Type) <u>Robert J. Wearn MD.</u>		PHYSICIAN'S NAME (Type) <u>Robert J. Wearn MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>APR 21, 1962</u>	<u>DENTON</u>	<u>DENTON, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vargis Moore</u>		ADDRESS <u>Denton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

1

(M)

X

(I)

0

TO HOSPITAL OR TO FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04386

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04382

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural			
c. LENGTH OF STAY IN 1b 23 years				d. STREET ADDRESS American Corner			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION American Corner				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roy Middle James Last Warren				4. DATE OF DEATH Month April Day 7 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1905		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of Store and Filling Station				10b. KIND OF BUSINESS OR INDUSTRY Harrington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Warren				14. MOTHER'S MAIDEN NAME Emma L. Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 166-03-2546		17. INFORMANT Address Mrs. Minnie E. Warren, Denton, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 173.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Brain DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to April 17, 1962 , that (I) (we) last saw the deceased alive on April 5, 1962 , and that death occurred at 7:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Dawson D George				22b. DATE SIGNED 4-9-62			
22c. PHYSICIAN'S NAME (Type) Dawson D George M.D.				22d. ADDRESS Denton Caroline Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 10, 1962		23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		23d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE APR 11 '62		25b. REGISTRAR'S SIGNATURE Charles L. Pinner	

04882

CERTIFICATE OF DEATH

01388



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04387

Reg. Dist. No. 04383

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 50 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle M. Last Whittington				4. DATE OF DEATH Month April Day 9 Year 19 62			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Thomas				14. MOTHER'S MAIDEN NAME Mary Gross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-9241		17. INFORMANT Marie Boyce Ridgely, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Few minutes Several years							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dawson O. George				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dawson O. George				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-62		22c. NAME OF CEMETERY OR CREMATORY Thomas Burial Ground		22d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais Greensboro, Md.				24a. REC'D BY REGISTRAR APR 13 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

DATE SIGNED
4-11-62

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1900		10:30 AM	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
1234 E. BALTIMORE ST.		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN THE CHEST	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
CLOCK REPAIRER		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE	
SIGNED		WITNESSED		CORONER		JURY		JUDGE		CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CAUSE		MANNER		DISEASE	
JAN 15 1900		10:30 AM		HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	

ORIGINAL FILED IN